Quality Management Strategy

Member Access:
Through on-site monitoring of the Home and Community Based Waiver (HCBW) providers utilizing the "Medicaid HCB Waiver On-Site Individual Case Review", the Department for Medicaid Services (DMS) ensures that referrals are processed within the required timeframe of seven (7) days from receipt of doctor's written or verbal order. DMS contracts with a Quality Improvement Organization (QIO) to conduct first line on site monitoring of all providers. One hundred (100) percent of providers are reviewed at least annually. Monitoring reports from the QIO are reviewed by DMS program staff to ensure all providers are monitored on at least an annual basis and all components of the monitoring tool are completed The DMS clinical staff conducts second line monitoring of 20% of overall QIO monitoring to ensure referrals are being processed timely. The Quality Review Group will review the results of the clinical staff review on a quarterly basis. Programmatic changes are made based on patterns or trends identified through these quarterly reviews.

DMS contracts with the Department for Community Based Services (DCBS) to conduct the technical and financial eligibility determinations for the Medicaid program. This contract is monitored by a full-time position within DMS. Any issues or trends are addressed by contract monitoring staff and corrective actions are taken to include revisions to the procedures manual or retraining of staff conducting the determination reviews. DMS makes the final decision regarding eligibility determinations.

An assessment to determine medical eligibility is conducted by a participating HCBW provider utilizing the "Medicaid Waiver Assessment Form, MAP-351A". The Quality Improvement Organization (QIO) reviews the MAP-351A and determines nursing facility level of care. DMS Quality Review Group monitors reports of the level of care determinations made by the QIO on a monthly basis. The DMS Quality Review Group reviews the case records for ten (10) percent of level of care determinations on a quarterly basis. Monitoring will include ensuring level of care determinations are made in accordance with waiver program policy and ensuring individuals are being referred to other appropriate community resources when the level of care is denied. DMS staff addresses areas of discrepancy with the QIO and conduct retraining of staff as indicated through analysis of the monitoring findings. Programmatic changes will be based on trends and patterns identified through this review.

At the time of assessment/reassessment HCBW case managers are required to inform HCBW members regarding choice of waiver versus

institutional services, choice of waiver services and choice of waiver providers. These choices are documented utilizing the "Long Term Care Facilities and Home and Community Based Program Certification Form, MAP-350" which must be maintained by the HCBW provider in each client record. DMS contracts with a Quality Improvement Organization (QIO) to conduct first line on site monitoring of all providers. One hundred (100) percent of providers are reviewed at least annually. The DMS clinical staff conduct second line monitoring of 20% of overall QIO monitoring to ensure full freedom of choice. The Quality Review Group will review the results of the clinical staff review on a quarterly basis. Programmatic changes will be made based on trends or patterns identified through these quarterly reviews.

Approved HCBW services are to be initiated upon receipt of prior authorization of requested services and verification of Medicaid eligibility. DMS ensures this requirement through the review of member records during the on-site monitoring visits and through the monitoring of claims payments during post payment reviews conducted at least annually. The monitoring tools utilized by the QIO and DMS staff is included as an attachment to this document.

Member-Centered Service Planning:
All HCBW members are assessed at the time of initial waiver application and reassessed annually, at a minimum (more frequently if a change in the member's condition warrants). These assessments are conducted utilizing the "Medicaid Waiver Assessment Form, MAP-351A". This assessment tool utilizes the member's level of functioning in the following areas: activities of daily living, instrumental activities of daily living, mental/emotional health and well-being; as well as, clinical and environmental information to determine if the member meets nursing facility level of care. The Case Manager works with the member in the care planning process. The assessment/reassessment information is utilized to develop the "Plan of Care/Prior Authorization for Home and Community Based Waiver Services, MAP 109-HCBW" form to reflect the type and amount of services being requested to address the members needs, including health and risk factors. Individual plans of care are developed on at least an annual basis and updated as needed based on changes in the member’s health or environmental status. During this process, the member is encouraged to participate in all areas of decision making. The HCBW provider must provide any needed education regarding this waiver program to the member. Implementation of the Individual Plans of Care are monitored by the QIO and also be DMS clinical staff during on site monitoring visits and by DMS during post payment reviews.

HCBW providers must supply and educate members regarding all services

available through the waiver program including the service definitions and any applicable limitations. These providers must also supply a listing and educate members of their freedom of choice of additional participating waiver service providers. This process is documented in each member's clinical record utilizing the "Long Term Care Facilities and Home and Community Based Program Certification Form, MAP-350". The maintenance of this documentation is verified through the on-site provider monitoring.

All HCBW members have a designated case manager who is employed by the HCBW provider. This case manager is responsible for the assistance in obtaining and coordination of all identified service needs of the member. These case managers are also responsible for responding to any matters of concern regarding the member's ability to remain in the community setting. The QIO monitors through the review of the member's clinical record during the HCBW provider's on-site monitoring visit to ensure the care planning process meets the above criteria. The DMS Quality Review Group will review the outcomes of the QIO monitoring and verify by review of at least ten (10) percent of member clinical records.

Provider Capacity and Capabilities:
The HCBW program offers statewide coverage to members. This statewide coverage also includes ample Adult Day Health Care (ADHC) providers. All HCBW providers are licensed Home Health Agencies (HHA) or licensed ADHC's. The HHA's must be Medicare certified prior to participating in the Commonwealth of Kentucky's Medicaid program. Both HHA's and ADHC's are licensed and reviewed annually through the Office of Inspector General (OIG). The OIG forwards copies of new license issues following each licensure survey. These are maintained in the DMS provider enrollment files and eligibility is updated in the system upon receipt. In addition, to OIG's annual audit, DMS and the Quality Improvement Organization (QIO) conduct on-site monitoring visits. DMS also updates provider enrollment files on an annual basis to ensure accurate ownership and licensure of all HCBW agencies as required.
At least annual GeoAccess reports are completed to reflect providers statewide to evaluate overall access to HCBW providers. Additionally, all complaints are logged and tracked regarding provider capacity and capability. Analysis is conducted by the Clinical Review Group quarterly and actions are taken to address issues. Programmatic changes will be made based on identified patterns or trends.

Post payment reviews are conducted at least annually for each provider. Approved Plans of Care are compared to claims payment reports to identify any errors made in payments and to ensure services billed are provided in accordance with the Individual’s plan of care and service

definitions. Recoupments are made for inappropriate payments and retraining of provider agency staff is conducted.

Member Safeguards:

HCBW member environmental assessment is included in the initial assessment or during the annual reassessment. This documentation is contained in the "Medicaid Waiver Assessment, MAP-351A" and is maintained in the member's clinical record. Any safety or welfare concerns contributing to the member's environment must be addressed during the care-planning phase.

DMS requires that all incidents (minor and major) are documented in the member's clinical record and the report maintained in a central file within the HCBW agency. These incidents may include but are not limited to: abuse, neglect and exploitation; slip or fall; transportation incidents; medication errors; medical complications; physical or verbal abuse of agency staff or other members; destruction or damage of property; and, member self-abuse. All incidents, outcomes and plans for prevention must reported to the member (member's guardian) and the member's attending physician, PA or ARNP. All major incidents are reported to the licensing agency, Office of Inspector General, within the Cabinet for Health and Family Services. Licensure staff review and determine necessary level of follow up. All incidents are maintained in a database. All incidents or allegations of abuse, neglect or exploitation are reported to the Department for Community Based Services in accordance with KRS 209. DMS Quality Review Group will review reports of all incidents and complaints on a quarterly basis. Any complaints received by DMS program staff are logged and tracked. DMS program staff will address issues as needed or report to other agencies identified above as appropriate. The Quality Review Group will review reports on a quarterly basis to identify patterns or trends. DMS utilizes this data to determine if additional onsite monitoring and/or training of providers is needed.

All HCBW providers are required to have written plans to address service provision in the event of natural disasters and other public emergencies. These plans are reviewed annually through the QIO and DMS on-site monitoring. Corrective action plans are required for findings identified through this monitoring process.

Member Rights and Responsibilities:

All HCBW members are informed of their rights and responsibilities at the time of initial application or annual recertification. This information is documented and maintained by the HCBW provider in the member clinical record. This documentation is reviewed annually by QIO and DMS on-site monitoring. DMS contracts with a Quality Improvement Organization (QIO) to conduct first line on site monitoring of all providers. One hundred (100) percent of providers are reviewed at least annually. The

DMS clinical staff conduct second line monitoring of 20% of overall QIO monitoring to ensure documentation is maintained by the HCBW providers reflecting each individual is informed of their rights and responsibilities and supported to exercise the providers internal grievance process. The Quality Review Group will review the results of the clinical staff review on a quarterly basis. Programmatic changes will be made based on trends or patterns identified through these quarterly reviews.

DMS provides all HCBW members written appeal rights anytime an adverse action is initiated. These appeals are held timely and fair hearing procedures are exercised through the Administrative Hearings Branch. DMS program and policy staff track and trend all appeals to identify criteria or regulatory language requiring modification.

HCBW providers are required to implement procedures to address member complaints and grievances. The providers are required to educate all members regarding this procedure and provide adequate resolution in a timely manner. Providers report all complaints and grievances to DMS on a quarterly basis for tracking and trending. DMS utilizes this data to determine if additional on-site monitoring and/or training of providers is needed.

Member Outcomes and Satisfaction:
Client satisfaction surveys are distributed to members during on-site monitoring visits. The members or guardians return these surveys to DMS. The DMS Quality Review Group utilizes the information to refine existing policy and regulations to ensure continuing satisfaction. DMS staff address, with the member or provider, any dissatisfaction identified on a survey.

Additionally, the 372 report and claims payment reports are monitored to identify over all utilization of services, number of enrollments and disenrollments and total program expenditures.

System Performance:
Through analysis of data obtained from the above-mentioned tools and reports, DMS modifies existing systems to ensure continuing quality and satisfaction. DMS routinely reviews all reports to identify changing trends so that proactive modifications may be implemented to ensure continuing quality care.

DMS staff routinely attend Association/provider conferences to present current changes and modifications to the program and provide policy clarification based on review and analysis of reports and on-site monitoring. The QIO conducts periodic training sessions for providers. DMS staff provide one-on-one provider training upon request or as the

need is identified through the monitoring and analysis process. The DMS Fiscal Agent provides training for providers regarding billing requirements or issues identified related to billing.